

“An Analytic Study of Death Anxiety among Type 2 Diabetes”

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Abstract

Several predisposing factors and traits in diabetics which muddle their behavioural patterns and disorient personality such as; arousing deep buried guilt over in oral demands, powerful unpredictable mood and behaviour changes that are a function of metabolic imbalance, denial, anxiety, hostility, depression, self-consciousness and passive-aggressive etc. Keeping these vital points in mind, this empirical research was conducted to analyse and find correlation of the death anxiety among diabetics and non diabetics. For this 200 samples from Hazaribag District were selected. Incidental cum purpose sampling technique was adopted. The samples were divided into two groups- diabetics and non diabetics. Again the subjects were divided on the basis of gender- (No.50-male diabetics) (No .50- female diabetics). - (No.50- non diabetics male) - (No.50- non diabetics female). Two scales namely Personal Data Sheet and Death Anxiety Scale by Upinder Dhar, Savita Mehta and Santosh Dhar were administered on these groups. Data was collected, tabulated and analysed with the help of Mean, SDs and t.-ratio of acquired data. And it was found that t was not significant. Imperative aspects like age, well settled retired life, religiosity, etc. enhance the self confidence of diabetics to surmount their death anxiety and it was also responsible for making no difference of death anxiety between both the diabetics and non diabetics.

Keywords: Analytic study; death anxiety; type 2 diabetes; non diabetics;

1. Introduction

1.1 Death Anxiety

Death is relief from reaction to the senses, from the puppet strings of impulse, from the analytic mind, and from service to the flesh. (Marcus Aurelius –Meditations)

The Oxford Dictionary defines death as the “end of life; ceasing to be; destruction” (1985).After birth death is inevitable every individual knows it. Pubilius Syrus (100 B.C.) stated in Maxims, “The fear of death is more to be dreaded than death itself.” The following statement from Bhagavad Gita is apt to be quoted here, “For certain is death for the born and certain is birth for the dead, therefore over the inevitable thou shouldst not grieve.”

Psychologist Janet Belsky, (1999) described “death anxiety” as: “the thoughts, fears, and emotions about that final event of living that we experience under more normal conditions of life”. Basically saying that people live their lives on a day to day basis and they endure varying degrees of anxiety concerning death. Research has tried to unveil the factors that might influence the amount of anxiety people experience in life.

1.2 Death Anxiety Studies

There have been many empirical studies of death anxiety, but many questions also remain because of methodological limitations and the difficulties inherent in this subject. Nevertheless, a critical review of the literature does reveal some interesting patterns:

- Most people report that they have a low to moderate level of death-related anxiety.
- Women tend to report somewhat higher levels of death-related anxiety.
- There is no consistent increase in death anxiety with advancing adult age. If anything, older people in general seem to have less death anxiety.
- People with mental and emotional disorders tend to have a higher level of death anxiety than the general

population.

- Death anxiety can spike temporarily to a higher level for people who have been exposed to traumatic situations.

"Death anxiety" is a term used to conceptualize the apprehension generated by death awareness (Abdel-Khalek, 2005). Humans are unique in that they must learn to live and adapt to the consciousness of their own finiteness (Becker, 1973). Thus, a major task for cultural systems is to provide a symbolic structure that addresses death and provides meaning for its occurrence and a context for its transcendence (Becker 1973; Kübler-Ross, 2002). Confronting death and the anxiety generated by knowledge of its inevitability is a universal psychological quandary for humans. For health care providers, death is an ever-present reality despite increasing technologically advanced health systems, longer patient survival, and cure from life-threatening conditions. Although helping individuals and their families manage death is a central responsibility of nursing worldwide and an increasing literature suggests that death anxiety contributes to important emotional and behavioural outcomes, theoretical and empirical background of the concept has not been systematically examined in the nursing literature. This limitation has led to a dearth of literature that has explored death anxiety as an important variable in empirical nursing inquiry, a finding that may compromise the development of interventions to assist nursing personnel and the myriad of patients affected in their ability to cope with this profound existential issue. To date, few efforts have been directed toward clarification of this critical concept in nursing (Nyatanga & de Vocht, 2006), although death anxiety is included as a nursing diagnosis with NANDA nursing outcome criteria (Carpenito-Moyer, 2008; Moorhead, Johnson, Maas, & Swanson, 2008).

Nyatanga and de Vocht (2006) argue that a clear and comprehensive theoretical definition of the death anxiety concept that integrates the divergent theoretical approaches is not found in the nursing literature despite its critical relevance to palliative care practice and research. Yet death anxiety is an important concept to consider in a wide range of practice settings, including community cancer screenings of healthy individuals, psychiatric care, acute and trauma care, chronic care, and paediatrics and in individuals facing diagnosis of a life-threatening illness.

1.3 Diabetes

Diabetes is possible to become one of the most widespread medically, scientifically challenging and economically taxing significant diseases of the 21st century. And globally the developed nations and many of the developing nations are becoming subject in its epidemic proportions.

This ubiquitous condition will have an ever-increasing impact on all aspects of medicine and public health Diabetes is the paradigm of a condition that necessitates a multidisciplinary and holistic approach to its care management and control of treatment. Primary care physicians, hospital physicians, surgeons, nurses, dieticians, psychologists and ophthalmologists etc. are all drawn into this process.

Diabetes mellitus is a chronic medical illness presenting a potential risk for multiple life-threatening medical complications, including blindness, kidney failure; wounds refusing to heal can cause amputation of body organs, heart disease, and stroke. Empirical literature suggests that tight metabolic control achieved through the adequate execution of self-care behaviours on the part of diabetic patients can significantly reduce the risk of developing such complications. Consequently, gaining a greater understanding of factors that determine diabetes, self-care practices are of vital importance.

There are three etiologically distinctive types of diabetes, type 1 and type 2 and Gestational diabetes mellitus. Other specific types of diabetes also exist.

Warning signs of diabetes: Frequent urination , Excessive thirst , Increased hunger , Weight loss , Tiredness , Lack of interest and concentration , Vomiting and stomach pain (often mistaken as the flu) , A tingling sensation or numbness in the hands or feet , Blurred vision , Frequent infections , Slow-healing wounds

Risk factors: Obesity, Diet and physical inactivity, Increasing age, Insulin resistance, Family history of diabetes, Ethnicity

Management of diabetes: Today, there is no cure for diabetes, but effective treatment exists. Good diabetes control means keeping your blood sugar levels as close to normal as possible. This can be achieved by a combination of the following:

Physical Activity: a goal of at least 30 minutes of moderate physical activity per day (e.g. brisk walking, swimming, cycling, dancing) on most days of the week.

Body weight: weight loss improves insulin resistance, blood glucose and high lipid levels in the short term, and reduces blood pressure. It is important to reach and maintain a healthy weight.

Healthy Eating: avoiding foods high in sugars and saturated fats, and limiting alcohol consumption.

Avoid tobacco: tobacco use is associated with more complications in people with diabetes.

Monitoring for complications: monitoring and early detection of complications is an essential part of good diabetes care. This includes regular foot and eye checks, controlling blood pressure and blood glucose, and assessing risks for cardiovascular and kidney disease.

1.4 India and global scenario of diabetes

The numbers of diabetic patients are speedily mounting all over the world, but the trends are different for both developed and developing countries. At some places growth rate is faster than the others. According to recent estimates, approximately 285 million people worldwide (6.6%) in the 20-79 year age group will have diabetes in 2010 and by 2030, 438 million people (7.8%) of the adult population, is expected to have diabetes. (1) The largest increases will take place in the regions dominated by developing economies. A survey conducted by World Health Organization shows that the largest number of diabetic patients in the world is in India; hence India has been accorded the status of "Diabetic Capital" of the world. In 1995 every 7th diabetic person in the world was an Indian and by 2025 every 5th diabetic person will be an Indian. In 1995 the number of diabetic patients in India was 1.94 Crores and by 2025 this number will swell up to 5.70 Crores. The number of diabetic patients is rapidly increasing in India but what is more worrying is the factor that the younger age group is being more affected. At present 30% of the diabetic patients are in the age group of 20 to 40 years.

2. Literature review

2.1 Death anxiety and Diabetes

'Death anxiety' is a term used to conceptualize the apprehension generated by death awareness (Abdel-Khalek, 2005). Humans are unique in the sense that they must learn to live and adapt to the consciousness of their own finiteness (Becker, 1973). Thus, a major task for cultural systems is to provide a symbolic structure that addresses death and provides meaning for its occurrence and a context for its transcendence (Becker 1973; Kubler-Ross, 2002). Confronting death and the anxiety generated by knowledge of its inevitability is a universal psychological quandary for humans. For health care providers, death is an ever-present reality despite increasing technologically advanced health systems, longer patient survival, and cure from life-threatening conditions. Although helping individuals and their families manage death is a central responsibility of nursing worldwide and an increasing literature suggests that death anxiety contributes to important emotional and behavioural outcomes, theoretical and empirical background of the concept has not been systematically examined in the nursing literature. This limitation has led to a dearth of literature that has explored death anxiety as an important variable in empirical nursing inquiry, a finding that may compromise the development of interventions to assist nursing personnel and the myriad of patients affected in their ability to cope with this profound existential issue. To date, few efforts have been directed toward clarification of this critical concept in nursing (Nyatanga and De Vocht, 2006), although death anxiety is included as a nursing diagnosis with NANDA nursing outcome criteria (Carpenito-Moyer, 2008; Moorhead, Johnson, Maas, and Swanson, 2008).

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In India, researches on death anxiety began to appear as far back as 1978 and number of variables such as religion, age, sex, malignancy, and other factors were taken into account, bulk of this research was done at the Aligarh Muslim University.

In his conclusions, Swarup (1981) states that every religion has its own philosophy, rituals, theology and mythology. And all of these may be responsible in creating different attitudes toward death in individuals belonging to different religions. The study indicates that Christians and Muslims express more death anxiety than Hindus and Sikhs. This does not mean that every Christian or Muslim expresses a high death anxiety. If it had been so then every Christian and Muslim should have scored high on Death Anxiety Scale, but there are Christian and Muslims whose death anxiety scores are less than the death anxiety of Hindus and Sikhs. This does suggest that religion alone is not responsible for the high death anxiety score of Christians and Muslims. Death does not mean the same thing to different members of the

same society, because different personalities have different kinds of attitudes toward death and dying. Actually, the fear of death anxiety is a very complex thing and to explain it through one or two variables does not seem to be very meaningful. Another suggestion which arises out of the findings is that the mystic orientation in religions might be different from the orientation which emphasizes a mechanical adherent's ritual.

Dennis and Salma (1987) studied the relationship between fear of death and religiosity using a sample of 84 Saudi Arabian males, all Muslims who temporarily resided in the US for less than 2 years. Fear of death and dying was, measured using a factor analytic multi-dimensional Fear of Death and Dying Scale reported by D.D. Long (1987). Measures of religiosity included S. Putney and R. Middleton's (1961) Religious Orthodoxy Scale. Results indicated that current Church (Mosque) attendance has a significant negative correlation with fear of premature death, and self-perceived religiosity has a significant correlation with fear for significant others.

Padmanabhan and Chadha (1989) studied the relationship between death anxiety, religiosity, locus of control and self concept among late adolescents. Significant positive correlates were found to exist between locus of control and death between locus of control and religiosity and between perceived self and ideal self. No significant relationships existed between locus of control and perceived self, locus of control and ideal self, death anxiety and religiosity, death anxiety and perceived self, religiosity and perceived self.

Neimeyer and Chapman (1980) discovered that the group with a large split between their ideal self-scored as significantly more apprehensive than the group with little discrepancy. Obviously, subjects who perceive a discrepancy between what they are and what want to be, found death more frightening than subjects who perceive little discrepancy.

William, Walter and Barber (1987) investigated the relationship between religious belief and death anxiety the utility of the 4-fold typology with death anxiety as a dependent measure, and the relationship between death anxiety and assertiveness, using scales completed by 107 undergraduates. Findings suggest that death anxiety were lower in subjects with strong, integral, religious beliefs and grater in subjects with more expedient religious views.

Carter (1983) conducted a study entitled-locus of control, attitude toward split activity and death anxiety among male and female undergraduate's and found that locus of control can predict death anxiety in females. Lenwing (1976) found a curvilinear relationship between religiosity and fear of death in 40 residents of Utah. Williams and Cole (1968) divided subjects into high, intermediate, and low religiosity groups on the basis of religious participation. They found that the intermediate group yielded the highest self-report apprehension about death.

Beg and Zilli (1982) report that death anxiety may be related to (1) process of dying (2) the fact of death and (3) the consequences of death. Thoughts about the process of dying might include such parameters as death during sleep, death under anaesthesia, slow onset of death, sudden death, death under anaesthesia, slow onset of death, sudden death, and death due to fatal accident. The fact of death might include death as an agonizing experience, death as a relief from a painful life, and death as furtherance into a future life.

A recall test was then administered. Results indicate no significant group differences on recall performance. Initial no-show rates for the second part of the experiment were observed in the 4 groups reflecting a significant negatives relationship between death anxiety and initial no-show rates. The possibility of defensive responding on the DAS is suggested.

Consequences of death may have two major dimensions; (a) this worldly and (b) other worldly. Death anxiety in terms of a this-worldly dimension may centre on the fear of annihilation, apprehensions concerning the fate of family and dependents, dissolution of one's identity and an unaccomplished life. On the other-worldly dimensions, fear of death can be meaningfully understood in the background of a particular philosophy of religion which governs thoughts, beliefs, attitudes and the manner of concern with death. Hence, meaning of the terms, religious involvement, religious affiliation and strength of convictions seems to be derived from a particular philosophy of religion. The present investigator concluded that generalization around findings pertaining to the relationship of religious faith and death anxiety cannot be warranted without taking into account the meaning which is shared by individuals through a particular religious and cultural background.

Sinha and Naidu (1988) took a sample of 120 male heads of families, their ages 40-60 years. There were 60 heads of settled and 60 heads of unsettled families with 30 from high proximity and 30 from low proximity to death sight areas. Death and non-death pictures rated on 9 point scale, on bipolar dimension were used. The results were as follows- degree of exposure and state of families had significant main and interaction effects. But the means did show a non-significant trend in the expected direction. Low exposure subjects and heads of unsettled families had means which were insignificantly greater than the means of high exposure subjects and heads of settled families.

Theresa and Richard (1986) administered a 36 item instrument to measure anxiety levels regarding death of self, death of others, dying of self, and dying of others. Findings show that counselling subjects were significantly more

anxious regarding death and dying than were medical subjects. Death of others and dying of self were responsible for the overall differences between the groups. For both groups, the lowest anxiety scores were obtained for dying of other.

Schumaker, Barraclough and Vagy (1988) compared death anxiety in Malaysian and Australian individuals. The Malaysian subjects were 125 university students residing in Australia and the Australian subjects were 159 students at the same institutions. As predicted, Australian students had significantly, but slightly, higher death scores than Malaysian students. Females had significantly higher death anxiety scores than males in both samples. The findings are explained in terms of factors in Eastern cultures than more effectively control fear of death.

Kureshi and Husain (1981) have reported the twenty five male Palestinian students and the same number of their Indian counterparts, drawn from the Aligarh Muslim University graduate classes, were administered individually the Death Anxiety Scale (D.A.S.) and Dominance Scale (D.S.). The Palestinian students were found to score lower than the Indian students on the DAS, whereas dominance was found to be higher among the former than the latter. Besides, a negative relationship was discovered between death anxiety and dominance. Compared with the Indians a low amount of death anxiety among the Palestinian was explained mainly in terms of the sense of dedication to their cause, exposure to a threatening environment and a mental set of readiness to with stand any eventuality. Likewise, a higher score on dominance among the Palestinians was explained partly in terms of these factors as well as the contribution they were supposed to make to the liberation movement, requiring them to be assertive, ascendant and powerful.

These investigations in India, and abroad are based on the fundamental assumption that cultural differences happen to be most crucial in determining the meaning of death and in building up a death perspective in the mind of an individual. It is evident, however, that philosophical and ideological aspects cannot be isolated from the overall cultural framework.

Patterson et al (1987) administered a Threat Index and the Death Anxiety Scale (DAS) to 228 subjects. Based on the high/low criterion scores, 105 subjects were assigned to the following 4 groups: (1) high death threat/high death anxiety, (2) high death threat/low death anxiety, (3) low death threat/high death anxiety, and (4) low death threat/low death anxiety. Subject viewed a filmstrip on death rituals in various cultures.

Studies have explored the role that death experiences play in generating death anxiety. Among adolescents who had experienced the death of a grandparent, grief due to bereavement was the only significant predictor of death anxiety (Evans and Bond, 2005). Using an implicit test that measured death valence, anxiety, and denial in addition to a death anxiety scale, funeral studies students were shown to have lower explicit death anxiety and implicit death denial than general university students (Bassett and Dabbs, 2003). The study suggests that explicit death anxiety measures may underreport death anxiety experience and that educational exposures of the funeral students may reduce death denial (Bassett and Dabbs, 2003). The findings of variation between implicit and explicit death anxiety underscore the importance of construct attributes that may exist outside conscious awareness.

More experienced nursing students report higher death anxiety than do their less experienced counterparts (Chen, Del Ben, Fortson, and Lewis, 2006). Critical care nurses reported significantly more death anxiety, burnout, and stress compared with hospice nurses (Mallett, Price, Jurs, and Slenker, 1991). Similarly, Payne, Dean and Kalus (1998) found lower death anxiety and heightened recall of both positive and challenging patient care experiences among hospice nurses. Hospice philosophy approaches death as an essential component of living and, as such, openly confronts the issues associated with death's presence. A study examined the effects of palliative care training and death anxiety in palliative care volunteers. Topics such as spiritual issues from a multi faith and multicultural background, communication, the dying process, and grief and bereavement were included. While death anxiety scores did not change before and following training, participants felt better prepared and more competent to manage situations of clients facing terminal illness and death in this study (Claxton-Oldfield, Crain, and Claxton-Oldfield, 2007).

Consequences of death anxiety cluster around adaptive and maladaptive presentations.

Numerous studies have shown that when death awareness and its associated anxiety are increased, individuals respond by defending and/or intensifying their cultural beliefs (Pyszczynski et al., 2004). In Western cultures, the pursuit and possession of material objects or materialism, could also be a coping response to death anxiety (Arndt, Solomon, Kasser, and Sheldon, 2004; Rindfleisch and Burroughs, 2004). Collective endorsement of brands and consumerism may provide a sense of meaning, strengthen social ties and belonging, and enhance perceptions of power in achieving important life accomplishments. This in turn may improve self-worth and status perceptions, factors that insulate against death awareness and death anxiety (Rindfleisch and Burroughs, 2004).

Other researchers have found that death awareness and anxiety increase the sense of commitment in romantic relationships (Mikulincer, Florian, and Hirschberger, 2003). The researchers theorize that close relationships function as a death anxiety buffer, similar to self-esteem and cultural worldview (Mikulincer et al., 2003). A series of studies

examined whether death anxiety underlies emotional reactions toward individuals with disabilities (Hirschberger, Florian, and Mikulincer, 2005). Findings showed that males responded to death anxiety by withdrawing emotion and compassion, whereas females responded by increasing compassionate responses (Hirschberger et al., 2005). Death primes may motivate men and women to behave in culturally prescribed gender-stereotyped ways. Thus, males who have heightened death anxiety may respond with less compassion because they are socialized to display strength and to value independence and instrumentality. Females may be socialized to be responsive to the needs of others and to show concern and care (Hirschberger et al., 2005). Positive consequences of death anxiety experience may include new learning and growth, acceptance, enhanced life meaning, and the pursuit of an authentic existence (Firestone, 1993).

While death anxiety is both normal and universal, a significant consequence may be mental health problems. Death anxiety has been associated with heightened negative attitudes toward the elderly and anxiety toward aging (DePaola, Neimeyer, Lupfer, and Fiedler, 1992). Death anxiety has been found to predict posttraumatic stress reactions in individuals with spinal cord injuries (Martz, 2004). These individuals were less likely to have a future time orientation, suggesting an avoidance of projecting into the future the fact that death is inevitable with the lapse of time (Martz and Linveh, 2003). Death anxiety is also associated with eating and self-mutilation disorders (Farber, Jackson, Tabin, and Bachar, 2007; Jackson, Davidson, Russell, and Vandereycken, 1990). Death anxiety was found to be significantly higher among both males and females with clinical anxiety disorders when compared to nonclinical, schizophrenic, and addicted groups (Abdel-Khalek, 2005). It is thought that generalized anxiety and death anxiety share variance in that both hold negative emotions, characterized by worry, distress, insecurity, tension, and uneasiness, whether directed toward the threat of death or more general dangers (Abdel-Khalek, 2005). Further, death anxiety may lead to ambivalence toward the body, disruption in personal relationships, and withdrawal from sexual intimacy because the physical body serves as a reminder of death (Bassett, 2007; Goldenberg et al., 2006). More research is needed to determine if death anxiety increases as a result of existing psychiatric conditions or is a precursor to psychiatric conditions.

Pondering over the magnitude of alarming universal health hazard of diabetes, it was decided to measure the impact of death anxiety among diabetes and non diabetes.

3. Research methodology:

3.1 Aims:

1. To study the impact of type 2 diabetes on death-anxiety.
2. To compare the impact of death anxiety between type 2 diabetes and non diabetes

3.2 Hypothesis:

Keeping above mentions objectives in mind following hypothesis were formulated.

Diabetic patients will have higher level of death-anxiety than non-diabetic subjects. (Since diabetes affects vital organs like heart, kidney, eye, etc. There is fear of failure of these organs. The patients may die any time if the glucose level remains uncontrolled. The patient is always in fear of death. That is while the diabetic patients always remain under death-anxiety in comparison with their counterpart.)

3.3 Methodology:

3.3.1 Sample:

200 Samples were selected

3.3.2 Sample area:

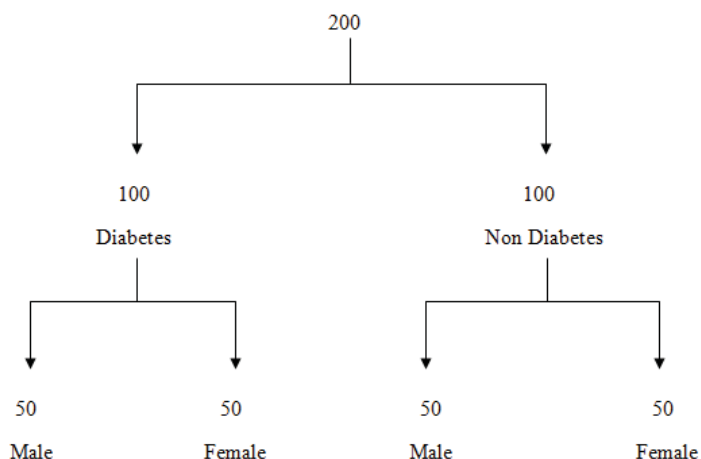
The sample area was Hazaribag district of Jharkhand in India

3.3.3 Sample Selection:

Random cum purposive sampling techniques was adopted because it was the most suitable method to the nature of

research problem.

3.3.4 Sample distribution:

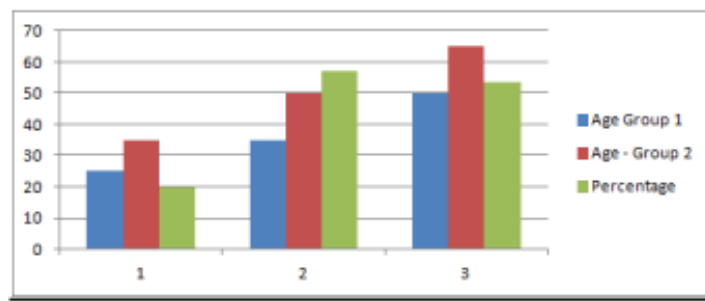


3.3.5 Demographic characteristic of the samples:

The sample was selected from various age groups. The age of the sample has represented in table 1.1.

Table-1.1

S No.	Age group	Percentage
1	25-35	19.8
2	35-50	56.9
3	50-65	23.3



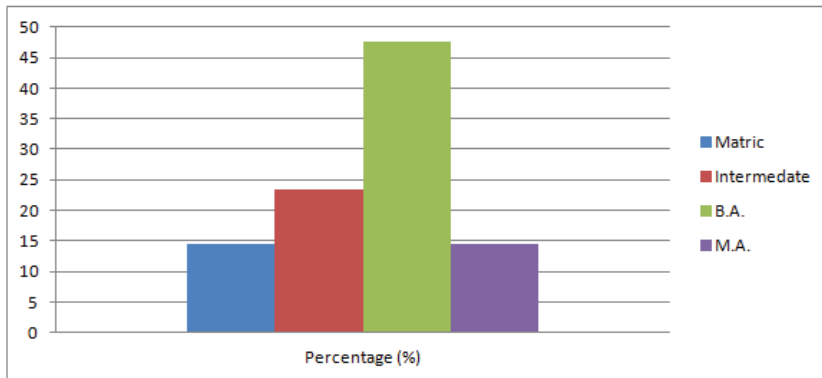
The above figure shows that more than half of the subjects were of middle age that is 35-50. Less number of employees was of old age (that is 19.8).

3.3.6 Qualification of the sample:

Subjects have different qualification. Some have master degree; some have graduation; some have intermediate degree and some had matriculation degree. This has represented in table 1.2.

Table-1.2. Qualification of the employees

Matric	Intermediate	Bachelor of Arts	Master of Arts
14.5%	23.4%	47.6%	14.5%



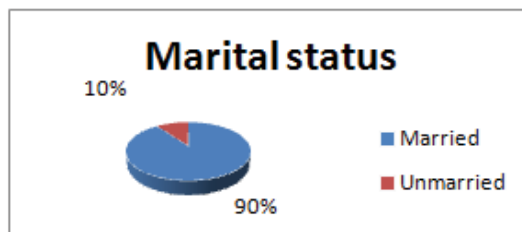
The above table shows that maximum numbers of employees were Graduate (that is 47.65)

3.3.7 Employment of the subjects:

Samples have different type of employment – Clerk, Supervisor, Engineer, Doctor, Bank Manager, etc.

3.3.8 Marital status of the sample:

Most of the subjects were married.



The above figure indicates that 90% of the employees were married.

3.4 Tools used:

Pondering over above aims and objectives of the research two tools were used.

3.4.1 Personal Data Sheet (PDS):

The PDS was used to get some information about demographic variables like, name, sex, qualification, history of diabetes, name of medicine and the like. This scale was prepared by the researcher himself.

3.4.2 Death Anxiety Scale:

This scale was used to measure the death anxiety of the sample. This scale has been developed by Upinder Dhar,

Savita Mehta and Santosh Dhar. This scale has 10 items with 'yes' and 'no' alternative. The reliability of this scale is 0.87 (split half reliability). Beside face validity the scale has high content validity.

3.5 Data Collection:

After deciding sample its location and its method of selection this researcher visited different diabetes centre and at the clinic of those physicians who were especially specialised for treating diabetes. The researcher contacted diabetic patients and took their confidence and consent immediately. Some patients filled the questionnaire same day and some took them to their home promising to return in next visit. In this way, the administered scale of the samples was procured and scoring was done in accordance with the manual, then data was collected and interpreted in light of standard statistical techniques.

4. Findings and discussion

The hypothesis of this work was (diabetic patients will have high level of death anxiety than non-diabetic). To verify this hypothesis two tools were used. One was personal data sheet. Which was prepared by researcher himself and the second tool was death anxiety scale developed by Upinder Dhar, Savita Mehta and Santosh Dhar. These two scales were administered on 200 samples. This was divided into two groups diabetic and non-diabetic. These two groups two were divided. Again into two groups on the basis of sex male and female. This two scales were administered on these groups and data was collected and tabulated in table no.-1.3, and demonstrated in Bar Graph of 1.3, 1.4 & 1.5.

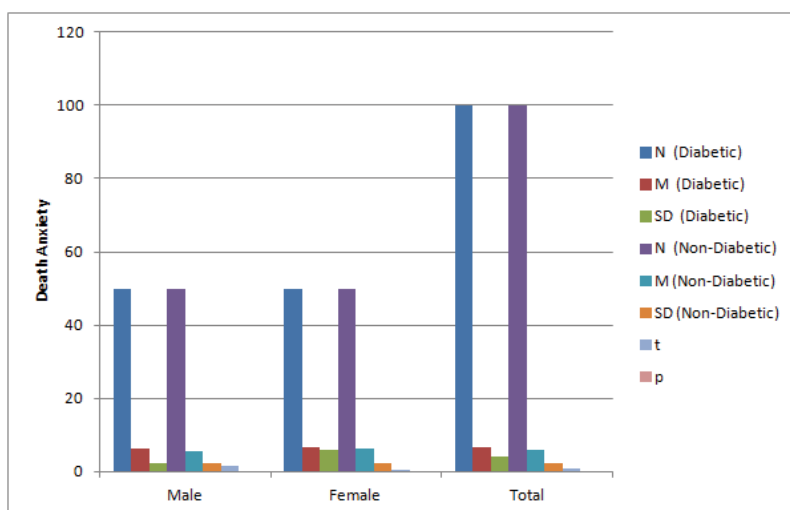
Pondering over this table 1.3, it is observed that it has three comparisons. The 1st comparison is between male diabetic and non-diabetic male. The 2nd comparison is between female diabetic and non-diabetic female. The 3rd comparison is between total diabetic and non-diabetic.

Table 1.3. (N, M, SD and t – ratio of diabetic and non – diabetic samples on Death Anxiety)

Group	Diabetic			Non-Diabetic			t	p
	N	M	SD	N	M	SD		
Male	50	6.36	2.43	50	5.54	2.41	1.67	Ns*
Female	50	6.56	5.81	50	6.36	2.10	0.23	NS*
Total	100	6.46	4.12	100	5.95	2.25	0.95	NS*

* NS = Not Significant

4.1 Group wise comparison of Diabetic and Non-Diabetic sample on Death Anxiety.



The 1st comparison will observed that 't' ratio between male diabetic and non-diabetic male is 1.67. Which is not

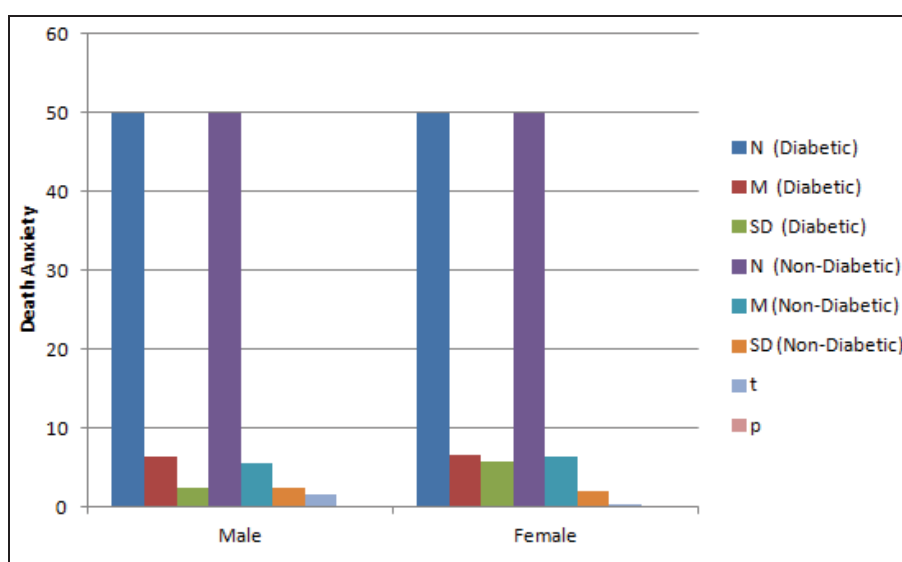
significant on any level it means this two groups are not significantly different on death anxiety. So, it can be said that male diabetic and non-diabetic male are not different on death anxiety.

Table 1.4. (N , M , SD and t – ratio of diabetic and non – diabetic samples on Death Anxiety)

Group	Diabetic			Non-Diabetic			t	/p
	N	M	SD	N	M	SD		
Male	50	6.36	2.43	50	5.54	2.41	1.67	Ns*
Female	50	6.56	5.81	50	6.36	2.10	0.23	NS*

* NS = Not Significant

4.2 Sub group wise comparison of Diabetic and Non-Diabetic sample on Death Anxiety.



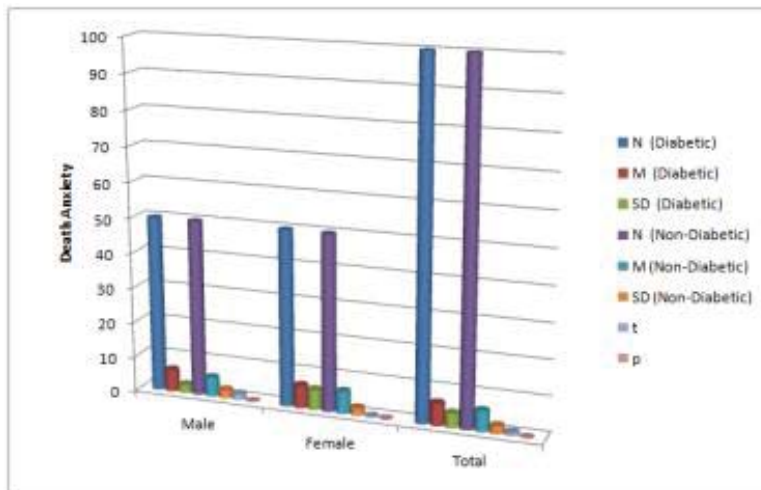
Considering 2nd comparison which is observed that 't' ratio these two female diabetic and non-diabetic is 0.23. This is not significant on any level it means these two groups do not differ significantly on death anxiety. In other word, this can be said that female diabetic and non-diabetic female are not different on death anxiety.

Table 1.5. (N , M , SD and t – ratio of diabetic and non – diabetic samples on Death Anxiety)

Group	Diabetic			Non-Diabetic			t	/p
	N	M	SD	N	M	SD		
Male	50	6.36	2.43	50	5.54	2.41	1.67	Ns*
Female	50	6.56	5.81	50	6.36	2.10	0.23	NS*
Total	100	6.46	4.12	100	5.95	2.25	0.95	NS*

* NS = Not Significant

4.3 Total comparison of Diabetic and Non-Diabetic sample on Death Anxiety.



Considering 3rd comparison, it is found that the 't' ratio between total group is 0.95. This is not significant on any level. It means both groups do not vary on death anxiety. In another words, it can be said that these two groups are not different on death anxiety.

Considering the three comparisons which is observed that this three 't' are not significant on any level. It means these diabetic and non-diabetic samples was not different on death anxiety group wise or sub-group wise. Through the hypothesis, which states that diabetic patients will have high level death anxiety than non-diabetic is rejected and null hypothesis is accepted and it is concluded that diabetic and non-diabetic samples do not differ on death anxiety.

5. Concluding Remarks

5.1 Death anxiety and Diabetes

The major aim of this research was to measure the impact of diabetes on death anxiety. For this, two scales namely Personal Data Sheet and Death Anxiety by Upinder Dhar, Savita Mehta and Santosh Dhar were applied on 200 samples. Data was collected and interpreted with the help of mean, SD and t. It was found that t was not significant. So, it can be concluded that there is no difference of death anxiety between diabetic and non-diabetic persons. So, it can be concluded that diabetes has no impact on death anxiety. Several factors were responsible behind this phenomenon. Most of the samples were more than 50 years old. They were almost free from their domestic responsibility. That is why diabetic and non-diabetic persons did not differ on death anxiety. Next measure cause behind this finding was freedom from settlement. Almost all sample were selected settled in Hazaribag district. They had their own house and there was no tension for livelihood. They had shed their own burden, which may produce anxiety. That is why the subjects did not varied on death anxiety. The next cause was settlement of their dependents and marriage of their children. The sample in this research has married their daughter, which is the main cause of anxiety with ultimate converts in death. The next important cause behind this finding is high level of religiosity of the sample. The samples were highly religious. Researches has proved that highly religious person have less death anxiety. Some sample was from Christian and Muslim communities, which has less death anxiety in comparison to other religious persons.

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